Mental Health and Substance Abuse Services

Adult Mental Health Day Treatment

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Refer to the Online Handbook for current policy

wisconsin Medicaid and BadgerCare

Information for Providers

Department of Health and Family Services

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Department of Health and Family Services

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M E M O R A N D U M

DATE: March 1, 2006

TO: Wisconsin Medicaid-Certified Adult Mental Health Day Treatment Providers

FROM: Mark Moody, Administrator
Division of Health Care Financing

SUBJECT: Wisconsin Medicaid Mental Health and Substance Abuse Services Handbook with Adult Mental Health Day Treatment section

The Division of Health Care Financing is pleased to provide a copy of two sections of the Mental Health and Substance Abuse Handbook. The General Information section of the handbook articulates current Medicaid policies found in Wisconsin Administrative Code, HFS 101-108, as they apply to mental health and substance abuse services.

The Adult Mental Health Day Treatment section incorporates current Medicaid mental health day treatment policy information into a single reference source. This section replaces Part H, Division III, the Medical Day Treatment handbook (issued April 1994) and the following service-specific *Wisconsin Medicaid and BadgerCare Updates:*

- The July 2003 *Update* (2003-71), titled "Changes to local codes, paper claims, and prior authorization for adult mental health day treatment services as a result of HIPAA."
- The April 2004 *Update* (2004-34), titled "Medical Record Documentation Requirements for Mental Health and Substance Abuse Services."
- The December 2004 *Update* (2004-88), titled "Coverage of Mental Health and Substance Abuse Services Provided Via Telehealth."
- The January 2005 *Update* (2005-08), titled "Wisconsin Medicaid Accepting Prior Authorization Requests Via the Web for Additional Service Areas."

All-Provider Publications
Providers are reminded to retain their all-provider publications. The revised Mental Health and Substance Abuse Services Handbook sections do *not* replace these publications.

Additional Copies of Publications

The Wisconsin Medicaid Web site, *dhfs.wisconsin.gov/medicaid/*, contains additional information for all Medicaid providers, service-specific information, and electronic versions of the Mental Health and Substance Abuse Services Handbook and the All-Provider Handbook.

Providers who have questions about the information in this handbook may call Provider Services at (800) 947-9627 or (608) 221-9883.

Contacting Wisconsin Medicaid

Web Site	***dhfs.wisconsin.gov/***
The Web site contains information for providers and recipients about the following: • Program requirements. • Publications. • Forms. • Maximum allowable fee schedules. • Professional relations representatives. • Certification packets.	Available 24 hours a day, seven days a week
Automated Voice Response System	**(800) 947-3544** **(608) 221-4247**
The Automated Voice Response system provides computerized voice responses about the following: • Recipient eligibility. • Prior authorization (PA) status. • Claim status. • Checkwrite information.	Available 24 hours a day, seven days a week
Provider Services	**(800) 947-9627** **(608) 221-9883**
Correspondents assist providers with questions about the following: • Clarification of program requirements. • Recipient eligibility. • Resolving claim denials. • Provider certification.	Available: 8:30 a.m. - 4:30 p.m. (M, W-F) 9:30 a.m. - 4:30 p.m. (T) Available for pharmacy services: 8:30 a.m. - 6:00 p.m. (M, W-F) 9:30 a.m. - 6:00 p.m. (T)
Division of Health Care Financing **Electronic Data Interchange Helpdesk**	**(608) 221-9036** **e-mail: *wiedi@dhfs.state.wi.us***
Correspondents assist providers with *technical* questions about the following: • Electronic transactions. • Companion documents. • Provider Electronic Solutions software.	Available 8:30 a.m. - 4:30 p.m. (M-F)
Web Prior Authorization Technical Helpdesk	**(608) 221-9730**
Correspondents assist providers with Web PA-related *technical* questions about the following: • User registration. • Passwords. • Submission process.	Available 8:30 a.m. - 4:30 p.m. (M-F)
Recipient Services	**(800) 362-3002** **(608) 221-5720**
Correspondents assist recipients, or persons calling on behalf of recipients, with questions about the following: • Recipient eligibility. • General Medicaid information. • Finding Medicaid-certified providers. • Resolving recipient concerns.	Available 7:30 a.m. - 5:00 p.m. (M-F)

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Preface

Wisconsin Medicaid and BadgerCare mental health and substance abuse services publications apply to fee-for-service Medicaid providers. The information in these publications apply to Medicaid and BadgerCare programs for recipients on fee-for-service Medicaid.

Medicaid is a joint federal and state program established in 1965 under Title XIX of the federal Social Security Act. Wisconsin Medicaid is also known as the Medical Assistance Program, WMAP, MA, Title XIX or T19.

BadgerCare extends Medicaid coverage through a Medicaid expansion under Titles XIX and XXI. The goal of BadgerCare is to fill the gap between Medicaid and private insurance without supplanting or "crowding out" private insurance. BadgerCare recipients receive the same health benefits as Medicaid recipients, and their health care is administered through the same delivery system.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing (DHCF) is directly responsible for managing Wisconsin Medicaid and BadgerCare.

Unless otherwise specified, all information contained in this and other Medicaid publications pertains to services provided to recipients who receive care through fee-for-service. Refer to the Managed Care section of the All-Provider Handbook for information about state-contracted managed care organizations.

Adult Mental Health Day Treatment Section

The information in the Adult Mental Health Day Treatment section of this Mental Health and Substance Abuse Handbook applies to Division of Disability and Elder Services, Bureau of Quality Assurance-certified adult mental health day treatment service programs.

Adult mental health day treatment providers should refer to the All-Provider Handbook, the General Information section of this handbook, and the Adult Mental Health Day Treatment section of this handbook to find answers to policy-related questions.

All-Provider Handbook

All Medicaid-certified providers receive a copy of the All-Provider Handbook, which includes the following sections:

- Certification and Ongoing Responsibilities.
- Claims Information.
- Coordination of Benefits.
- Covered and Noncovered Services.
- Informational Resources.
- Managed Care.
- Prior Authorization.
- Recipient Eligibility.

Providers are required to refer to the All-Provider Handbook for more information about these topics.

Wisconsin Medicaid and BadgerCare Web Sites

Publications (including provider handbooks and *Wisconsin Medicaid and BadgerCare Updates*), maximum allowable fee schedules, telephone numbers, addresses, and more information are available on the following Web sites:

- *dhfs.wisconsin.gov/medicaid/.*
- *dhfs.wisconsin.gov/badgercare/.*

Publications

Medicaid publications apply to both Wisconsin Medicaid and BadgerCare. Publications interpret and implement the laws and regulations that provide the framework for Wisconsin Medicaid and BadgerCare. Medicaid publications provide necessary information about program requirements.

Legal Framework

The following laws and regulations provide the legal framework for Wisconsin Medicaid and BadgerCare:

- Federal Law and Regulation:
  - ✓ Law — United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
  - ✓ Regulation — Title 42 CFR Parts 430-498 and Parts 1000-1008 (Public Health).

- Wisconsin Law and Regulation:
  - ✓ Law — Wisconsin Statutes: 49.43-49.499 and 49.665.
  - ✓ Regulation — Wisconsin Administrative Code, Chapters HFS 101-109.

Laws and regulations may be amended or added at any time. Program requirements may not be construed to supersede the provisions of these laws and regulations.

Provider and Recipient Information

Provider Certification

To seek reimbursement from Wisconsin Medicaid for providing adult mental health day treatment services to Medicaid recipients, an organization must first be certified by the Department of Health and Family Services, Division of Disability and Elder Services (DDES), Bureau of Quality Assurance (BQA), as meeting day treatment requirements under HFS 61.75, Wis. Admin. Code. To obtain information on certification under HFS 61.75, Wis. Admin. Code, providers may contact the DDES, BQA, by telephone at (608) 243-2025 or by mail at the following adddress:

Division of Disability and Elder Services
Bureau of Quality Assurance
Program Certification Unit
2917 International Ln Ste 300
Madison WI 53704
(608) 243-2025

After being certified by the DDES, BQA, an adult mental health day treatment provider may seek certification from Wisconsin Medicaid and can obtain mental health agency certification materials by doing one of the following:

- Downloading certification materials from the Medicaid Web site.
- Calling Provider Services at (800) 947-9627 or (608) 221-9883.
- Writing to the following address:

  Wisconsin Medicaid
  Provider Maintenance
  6406 Bridge Rd
  Madison WI 53784-0006

Refer to Appendix 1 of this section for more information about certification.

Refer to the General Information section of this handbook for more information about provider certification, provider numbers, and provider responsibilities.

Copayment

Providers are prohibited from collecting copayment from nursing home residents receiving adult mental health day treatment services. All other recipients receiving adult mental health day treatment services are required to pay copayment. Refer to Appendix 2 of this section for copayment amounts specific to adult mental health day treatment services.

Refer to the Recipient Eligibility section of the All-Provider Handbook for general copayment policies, exemptions, and limitations.

Managed Care Coverage for Day Treatment Services

State-contracted managed care organizations (MCOs) cover adult mental health day treatment services. Recipients enrolled in all state-contracted MCOs are required to receive adult mental health day treatment services through the MCO. Providers should check with the recipient's MCO for further information on coverage.

Wisconsin Medicaid strongly recommends that providers verify the recipient's current enrollment in an MCO before providing services. Claims submitted to Wisconsin Medicaid for adult mental health day treatment services covered by MCOs will be denied.

State-contracted managed care organizations (MCOs) cover adult mental health day treatment services.

Covered Services

The Adult Mental Health Day Treatment section contains information for providers of adult mental health day treatment services, also known as day hospital or partial hospitalization services. For the purposes of this handbook, the term "day treatment" will be used to refer to these services.

"Day treatment" or "day hospital" means a nonresidential program in a medically supervised setting that provides case management, medical care, psychotherapy and other therapies (including recreational, physical, occupational, and speech therapies), and follow-up services to alleviate problems related to mental illness or emotional disturbances, according to HFS 101.03(37), Wis. Admin. Code. Emotional disturbances under this definition are viewed as being directly related to, or part of, a diagnosed mental illness.

Day treatment services are provided by an interdisciplinary team on a routine, continuous basis for a scheduled portion of a day and may include structural rehabilitative activities including training in basic living skills, interpersonal skills, and problem-solving skills.

The adult mental health day treatment services described in this section are reimbursable only for recipients who are 18 years of age or older and are willing to participate in day treatment.

The adult mental health day treatment services described in this section are reimbursable only for recipients who are 18 years of age or older and are willing to participate in day treatment. When assessing recipients 18 to 21 years old, providers should consider whether child/adolescent day treatment services (a HealthCheck "Other Service") or adult mental health day treatment services are more appropriate for the recipient. For more information on child/adolescent day treatment, refer to Medicaid publications on these services.

Requirements

According to HFS 107.13(4), Wis. Admin. Code, adult mental health day treatment services may be reimbursed by Wisconsin Medicaid when the following conditions are met:

- The provider is certified by Wisconsin Medicaid as described in the General Information section of this handbook.
- There is a physician prescription for this service.
- Prior to involvement in the adult mental health day treatment program, the recipient is evaluated through the use of the functional assessment scale to determine the medical necessity for day treatment and the recipient's ability to benefit from it. The completion instructions and Mental Health Day Treatment Functional Assessment, HCF 11090, are located in Appendices 7 and 8 of this section for photocopying and may also be downloaded from the Medicaid Web site. Providers should also assess the recipient's willingness to participate in treatment at this time.
- A treatment plan is developed with the recipient based on the initial evaluation and includes measurable, individual goals/objectives, the specific treatment modalities (including identification of the specific group or groups to be used to achieve these goals), and the expected outcomes of treatment.
- The supervising psychiatrist approved, signed, and dated the treatment plan for the recipient and continues to review, sign, and date the treatment plan no less frequently than once every 60 days.

Covered Services

Wisconsin Medicaid reimburses a functional assessment whether or not the recipient meets the criteria for adult mental health day treatment services based on the assessment findings. Refer to Appendix 2 of this section for applicable modifiers to be used when submitting claims for functional assessments.

The following are examples of services covered by Wisconsin Medicaid when they are specifically identified in the recipient's treatment plan as being necessary to meet measurable goals/objectives:

- *Psychiatric services, including assessments, psychotherapy, and medication management.* Medication management may be provided by a registered nurse (RN). Group services related to recipients' medication and side effects may also be reimbursed by Wisconsin Medicaid.
- *Other individual or group counseling services, supportive psychotherapy, and symptom management.* Groups designed to educate the recipient about mental illness or about topics such as Acquired Immune Deficiency Syndrome with the intent of maximizing the recipient's functioning in the community may be reimbursed by Wisconsin Medicaid. Each group must be led by a qualified professional staff person (i.e., a licensed occupational therapist, Master's degree social worker, RN, licensed psychologist, or Master's degree psychologist) or one certified occupational therapy assistant and one other paraprofessional staff person. The qualified staff person(s) is required to be physically present throughout the group session and must perform or direct the service.
- *Specific skill development in communications or problem solving.* Examples include stress management and assertiveness training.
- *Specific skill development related to activities of daily living.* The skill development should enable the recipient to function at a higher level and to function independently. Examples include personal hygiene, cooking, budgeting, health, and nutrition.
- *Pre-employment services to assist the recipient in gaining and using skills necessary for employment.* These services should not be job specific; instead, they should include activities to reduce a recipient's anxiety, manage symptoms on the job, and educate about appropriate job-related behavior.
- *Other occupational, physical, social, recreational, or speech therapies.* These services must be recognized in the professional literature as acceptable and effective treatments that enable adults with acute or long-term mental illness to function with greater independence.
- *Face-to-face crisis intervention services.* These services may be provided when they are consistent with the recipient's overall treatment goals, even though they are not identified in the treatment plan.
- *Substance abuse treatment and educational services.* These services may be provided to adult mental health day treatment recipients when the staff providing the services is knowledgeable about the special needs of individuals who have coexisting mental illnesses.

  Providers are required to meet the staffing requirements identified in HFS 107.13(4)(a)8, Wis. Admin. Code (i.e., at least one qualified staff person is required to lead the service and be present in the room throughout the session).

Face-to-face crisis intervention services...may be provided when they are consistent with the recipient's overall treatment goals, even though they are not identified in the treatment plan.

Services Provided Via Telehealth

Individual adult mental health day treatment services may be provided via Telehealth. Refer to the General Information section of this handbook for Telehealth requirements and claims submission.

Reimbursement Limitations

Wisconsin Medicaid does not reimburse the following services or circumstances in accordance with HFS 107.13(4)(c), Wis. Admin. Code:

- All assessment hours beyond six hours in a calendar year shall be considered part of the treatment hours and shall become subject to the relevant prior authorization (PA) limits. Day treatment assessment hours shall be considered part of the six hour per two-year mental health evaluation limit.
- Reimbursement for a day treatment service shall be limited to actual treatment time and may not include time devoted to meals, rest periods, transportation, recreation or entertainment.
- Reimbursement for day treatment services shall be limited to no more than two series of day treatment services in one calendar year related to separate episodes of acute mental illness. All day treatment services in excess of 90 hours in a calendar year provided to a recipient who is acutely ill shall be prior-authorized.
- Services under HFS 107.13(4)(c), Wis. Admin. Code, are not reimbursable if the recipient is receiving community support program services under HFS 107.13(6), Wis. Admin. Code.

Day treatment services that are primarily social or educational in nature and that include recreational programming [are not reimbursable]. These are considered nonmedical services and are therefore noncovered regardless of the age group served.

Noncovered Services

The following services are not covered by Wisconsin Medicaid, in accordance with HFS 107.13(4)(d), Wis. Admin. Code:

- Day treatment services which are primarily recreation oriented and which are provided in nonmedically supervised settings, such as 24-hour day camps or other social service programs. These include sports activities, exercise groups, activities such as craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours.
- Day treatment services which are primarily social or educational in nature, in addition to having recreational programming. These are considered nonmedical services and are therefore noncovered regardless of the age group served.
- Consultation with other providers or service agency staff regarding the care or progress of a recipient.
- Prevention or education programs provided as an outreach service, case-finding, and reading groups.
- Aftercare programs, provided independently or operated by, or under contract to, boards.
- Medical or substance abuse day treatment for recipients with a primary diagnosis of substance abuse or dependence.
- Day treatment provided in a recipient's home.
- Court appearances, except when necessary to defend against commitment.

Special Circumstances

The following requirements apply specifically to mental health day treatment services:

- All mental health day treatment services require a physician prescription/order.
- Wisconsin Medicaid reimburses the provision of services. Documenting the services provided is part of the provision of services.

Documentation Requirements

Refer to Appendix 14 for documentation requirements for all mental health and substance abuse service providers, including adult mental health day treatment providers. For additional information regarding documentation requirements, refer to the General Information section.

Providers are required to maintain a copy of the functional assessment scale in each recipient's medical record. Refer to Appendices 7 and 8 of this section for completion instructions and a copy of the Mental Health Day Treatment Functional Assessment.

Providers are reminded to adequately document the purpose of groups as a part of day treatment, the recipient's needs as they relate to the group, and either the specific goals the recipient is attempting to meet by taking part in the group or the recipient's response to group intervention.

Providers are required to maintain a copy of the functional assessment scale in each recipient's medical record.

Prior Authorization

Prior authorization is required for all adult mental health day treatment services for recipients receiving concurrent mental health or substance abuse services under HFS 107.13(4)(b)1c, Wis. Admin. Code.

Providers are required to obtain prior authorization (PA) for adult mental health day treatment services specified in this chapter. Authorization for services must be received *before* providing services for which PA is required.

Refer to the General Information section of this handbook for other general PA requirements. Refer to the Prior Authorization section of the All-Provider Handbook for additional PA information, the PA review process, submitting PA requests, grant dates, and renewal requests. Refer to Appendix 6 of this handbook for general PA guidelines for adult mental health day treatment services.

Services Requiring Prior Authorization

Prior authorization is required before providing the following services:

- Day treatment services provided beyond 90 hours in a calendar year.
- All day treatment services provided to residents of a nursing home.
- All day treatment services provided to recipients who are concurrently receiving psychotherapy, occupational therapy, or substance abuse services.

Prior Authorization Categories

For the purposes of PA, the delivery of adult mental health day treatment services is divided into three categories:

- *Rehabilitation.* Rehabilitation day treatment services are for recipients with initial, acute mental health problems.
- *Maintenance.* Maintenance day treatment services are for recipients with long-term, relatively stable mental health problems.
- *Stabilization.* Stabilization day treatment services are for recipients who experience decompensation or acute exacerbation of a long-term mental health problem.

Wisconsin Medicaid reviews and adjudicates PA requests on a case-by-case basis. It is therefore essential that adequate, explicit clinical information be provided on each PA request. Refer to Appendix 6 of this section for Medicaid guidelines for PA of adult mental health day treatment services.

Concurrent Mental Health Prior Authorizations

Prior authorization is required for all adult mental health day treatment services for recipients receiving concurrent mental health or substance abuse services under HFS 107.13(4)(b)1c, Wis. Admin. Code. Recipients involved in primary substance abuse treatment (intensive or day treatment) will generally not be eligible for concurrent adult mental health day treatment. Prior authorization for adult mental health day treatment may be granted concurrently with outpatient psychotherapy or substance abuse treatment when it is determined to meet the requirements of HFS 107.02(3), Wis. Admin. Code, and the provider documents that all three of the following conditions are met:

- Both services are diagnostically appropriate for the recipient.
- The providers are communicating with each other about the recipient's needs, the treatment is coordinated, and the day treatment services augment the other outpatient services.
- One of the following statements is true:
  - ✓ There is a pre-existing relationship between the recipient and the outpatient provider.

- ✓ The recipient has appropriate day treatment needs, and the recipient has a need for specialized intervention that the day treatment staff is not trained to provide.
- ✓ The recipient is transitioning from day treatment to outpatient services.

In general, a recipient who is able to benefit from outpatient services will not require as high a level of day treatment services and Wisconsin Medicaid may modify the hours requested based on clinical judgment.

Procedures for Obtaining Prior Authorization

To request PA for adult mental health day treatment services, providers need to submit the following completed forms to Wisconsin Medicaid:

- *Prior Authorization Request Form* (PA/RF), HCF 11018. The completion instructions and a completed sample PA/RF are located in Appendices 4 and 5 of this section. Prior Authorization Request Forms can be obtained by contacting Provider Services.
- *Prior Authorization/Adult Mental Health Day Treatment Attachment* (PA/AMHDTA), HCF 11038. The completion instructions and form are located in Appendices 9 and 10 of this section for photocopying and may also be downloaded from the Medicaid Web site.
- *Mental Health Day Treatment Functional Assessment,* HCF 11090, (Section I only). The completion instructions and form are located in Appendices 7 and 8 of this section for photocopying and may be downloaded from the Medicaid Web site.

Backdating Prior Authorization Requests

Refer to the General Information section of this handbook for information on backdating.

Claims Submission

To receive reimbursement, claims and adjustment requests must be received by Wisconsin Medicaid within 365 days of the date of service (DOS). To receive reimbursement for services that are allowed by Medicare, claims and adjustment requests for coinsurance, copayment, and deductible must be received by Wisconsin Medicaid within 365 days of the DOS, or within 90 days of the Medicare processing date, whichever is later.

For more information about exceptions to the claims submission deadline, Medicaid remittance information, adjustment requests, and returning overpayments, refer to the Claims Information section of the All-Provider Handbook.

Providers are encouraged to submit claims electronically since electronic claims submission usually reduces claim errors.

Coordination of Benefits

Except for a few instances, Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service. Therefore, the provider is required to make a reasonable effort to exhaust all existing other health insurance sources before submitting claims to Wisconsin Medicaid or to state-contracted managed care organizations.

Refer to the Coordination of Benefits section of the All-Provider Handbook for more information about services that require other health insurance billing, exceptions, claims submission procedures for recipients with other health insurance, and the Other Coverage Discrepancy Report, HCF 1159.

Diagnosis Codes

All diagnoses must be from the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) coding structure. Claims received without an allowable ICD-9-CM code are denied.

Refer to Appendix 2 of this section for adult mental health day treatment diagnosis code restrictions.

Procedure Codes

Healthcare Common Procedure Coding System (HCPCS) codes are required on all adult mental health day treatment claims. Claims or adjustments for adult mental health day treatment services without a HCPCS code are denied. The allowable HCPCS code and modifiers for adult mental health day treatment are listed in Appendix 2 of this section.

Time billed for functional assessments is limited to six hours every two years.

Place of Service Codes

Allowed place of service codes for adult mental health day treatment are included in Appendix 3 of this section.

837 Health Care Claim: Professional

Providers are encouraged to submit claims electronically since electronic claims submission usually reduces claim errors. Claims for adult mental health day treatment services may be submitted using the 837 Health Care Claim: Professional transaction, except when submitting claims that require additional documentation. In these situations, providers are required to submit paper claims.

Refer to the Informational Resources section of the All-Provider Handbook for more information about electronic transactions.

CMS 1500

Paper claims for adult mental health day treatment services must be submitted using the CMS 1500 claim form dated 12/90. Wisconsin Medicaid denies claims for adult mental health day treatment services submitted on any paper claim form other than the CMS 1500.

Wisconsin Medicaid does not provide the CMS 1500 claim form. The form may be obtained from any federal forms supplier.

Refer to Appendix 11 of this section for claim form instructions for adult mental health day treatment services. Appendices 12 and 13 are samples of claims for adult mental health day treatment services.

Reimbursement

Certified adult mental health day treatment providers are reimbursed at the lesser of the provider's usual and customary charge or the maximum allowable fee established by the Department of Health and Family Services. The maximum allowable fee is a comprehensive hourly rate that is paid for any allowable day treatment service regardless of which staff person provided the service or whether the service was a group or individual service.

Hospitals that have certified adult mental health day treatment programs should not include the Medicaid charges associated with the day treatment cost center in the Medicare/ Medicaid Cost Report. Adult mental health day treatment services are not considered hospital outpatient services.

Hospitals that have certified adult mental health day treatment programs should not include the Medicaid charges associated with the day treatment cost center in the Medicare/Medicaid Cost Report.

Appendix

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Refer to the Online Handbook
for current policy

Appendix 1
Medicaid Certification Requirements for Adult Mental Health Day Treatment Services

This appendix outlines Medicaid certification requirements for adult mental health day treatment service providers. Prior to obtaining Medicaid certification, adult mental health day treatment providers are required to be certified by the Department of Health and Family Services (DHFS), Division of Disability and Elder Services (DDES), Bureau of Quality Assurance (BQA). County/tribal social or human services agencies that request billing-only status do not need to be certified by the DDES.

The following terms are used in the table:

- "Agency Providing the Service" — The agency whose staff actually performs the service.
- "Agency Only Allowed to Bill the Service" — The agency that submits claims to Wisconsin Medicaid for the service. This agency does not perform the service but contracts with a provider to perform the service on the billing agency's behalf. The provider may be a certified program within the billing agency. Only a county/tribal social or human services agency can be a billing agency.

The following table lists required provider numbers and definitions for agencies providing mental health and substance abuse services.

Definitions for Provider Numbers	
Type of Provider Number	**Definition**
Billing/Performing Provider Number	Issued to providers to allow them to identify themselves on claims as either the biller of services or the performer of services.
Billing-Only Provider Number	Issued to a county/tribal social or human services agency to allow them to serve as the biller of services when contracting with a service performer.

Type of Agency	**Certification Requirements**				**Type of Provider Number Assigned**
	Division of Disability and Elder Services, Bureau of Quality Assurance	**Wisconsin Medicaid**	**Specific Certification Section of the Medicaid Mental Health/ Substance Abuse Agency Packet to Be Completed**	**County/ Tribal Social or Human Services Agency?**	
Agency Providing the Service	The agency is required to obtain a Wisconsin DHFS certificate to provide mental health day treatment services as authorized under HFS 61.75, Wis. Admin. Code.	The agency is required to: • Have a DDES, BQA certificate on file. • Complete and submit a Mental Health/Substance Abuse Agency Certification Packet.	Mental Health Day Treatment for Adults	No	Adult mental health day treatment services billing/perfor-ming provider number
Agency Only Allowed to Bill the Service	Not required	The agency is required to complete and submit a Mental Health/Substance Abuse Agency Certification Packet to be a billing-only provider for mental health day treatment services. An allowable Medicaid billing/ performing provider is required to perform the service.	Mental Health Day Treatment for Adults	Yes	Adult mental health day treatment services billing provider number

Appendix 2
Allowable Procedure Code and Copayment Amounts for Adult Mental Health Day Treatment Services

The following table lists the Healthcare Common Procedure Coding System (HCPCS) procedure code and modifiers that providers are required to use when requesting prior authorization and submitting claims for adult mental health day treatment services.

HCPCS Code	Description	Program Modifier Code	Service Modifier Code	Allowable ICD-9-CM Diagnosis Codes*	Copay**	Telehealth Services Covered?	Prior Authorization Required?
H2012	Behavioral health day treatment, per hour	**HE** Mental health program	None	295-302.9 306-309.9 311-316	$.50/day	For individual services only	Yes, for: • Day treatment services provided beyond 90 hours in a calendar year. • Services provided to recipients residing in a nursing home. • Recipients concurrently receiving psychotherapy, occupational therapy, or substance abuse services.
	Behavioral health day treatment, per hour	**HE** Mental health program	**U6** Functional Assessment	Diagnosis code required, no restrictions	$.50/day	Yes	No

* ICD-9-CM = *International Classification of Diseases, Ninth Revision, Clinical Modification*. The list of ICD-9-CM diagnosis codes for adult mental health day treatment is inclusive. However, not all Medicaid-covered adult mental health day treatment services are appropriate or allowable for all diagnoses. Wisconsin Medicaid bases approval of services on a valid diagnosis, acceptable adult mental health day treatment practice, and clear documentation of the probable effectiveness of the proposed service.

** Providers are prohibited from collecting copayment from nursing home residents receiving adult mental health day treatment services.

Appendix 3
Allowable Place of Service Codes for Adult Mental Health Day Treatment Services

The following table lists the allowable place of service (POS) codes that adult mental health day treatment providers are required to use when submitting prior authorization requests and claims. Adult mental health day treatment services may be provided in the following POS by certified adult mental health day treatment programs only.

Code	Description
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
22	Outpatient Hospital
50	Federally Qualified Health Center
71	State or Local Public Health Clinic
72	Rural Health Clinic

Appendix 4
Prior Authorization Request Form (PA/RF) Completion Instructions for Adult Mental Health Day Treatment Services

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. The Prior Authorization Request Form (PA/RF), HCF 11018, is used by Wisconsin Medicaid and is mandatory when requesting PA. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Providers may submit PA requests, along with the Prior Authorization/Adult Mental Health Day Treatment Attachment (PA/AMHDTA), HCF 11038, by fax to Wisconsin Medicaid at (608) 221-8616 or by mail to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — PROVIDER INFORMATION

Element 1 — Name and Address — Billing Provider

Enter the name and complete address (street, city, state, and zip code) of the billing provider. The name listed in this element must correspond with the Medicaid provider number listed in Element 4. *No other information should be entered in this element, since it also serves as a return mailing label.*

Element 2 — Telephone Number — Billing Provider

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

Element 3 — Processing Type

Enter processing type "129" for adult mental health day treatment services. The processing type is a three-digit code used to identify a category of service requested.

Element 4 — Billing Provider's Medicaid Provider Number

Enter the eight-digit Medicaid provider number of the billing provider. The provider number in this element must correspond with the provider name listed in Element 1. The correct suffix for a certified adult mental health day treatment program is "26."

SECTION II — RECIPIENT INFORMATION

Element 5 — Recipient Medicaid ID Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the recipient's Medicaid identification card or the Medicaid Eligibility Verification System (EVS) to obtain the correct identification number.

Element 6 — Date of Birth — Recipient

Enter the recipient's date of birth in MM/DD/YY format (e.g., September 8, 1966, would be 09/08/66).

Element 7 — Address — Recipient

Enter the complete address of the recipient's place of residence, including the street, city, state, and zip code. If the recipient is a resident of a nursing home or other facility, include the name of the nursing home or facility.

Element 8 — Name — Recipient

Enter the recipient's last name, followed by his or her first name and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 9 — Sex — Recipient

Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 10 — Diagnosis — Primary Code and Description

Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service requested.

Element 11 — Start Date — SOI (not required)

Element 12 — First Date of Treatment — SOI (not required)

Element 13 — Diagnosis — Secondary Code and Description

Enter the appropriate secondary ICD-9-CM diagnosis code and description relevant to the service requested, if applicable.

Element 14 — Requested Start Date (not required)

Enter the requested start date for service(s) in MM/DD/YY format, if a specific start date is requested. If backdating is requested, include the clinical rationale for starting before PA was received. Backdating is not allowed on subsequent PA requests.

Element 15 — Performing Provider Number (not required)

Element 16 — Procedure Code

Enter the appropriate Healthcare Common Procedure Coding System (HCPCS) procedure code for each service requested.

Element 17 — Modifiers

Enter the modifier(s) corresponding to the procedure code listed if a modifier is required by Wisconsin Medicaid.

Element 18 — POS

Enter the appropriate place of service code designating where the requested service would be provided.

Element 19 — Description of Service

Enter a written description corresponding to the appropriate HCPCS procedure code for each service requested.

Element 20 — QR

Enter the appropriate quantity requested for each procedure code listed.

Element 21 — Charge

Enter the provider's usual and customary charge for each service requested. If the quantity is greater than "1," multiply the quantity by the charge for each service requested. Enter the total amount in this element.

Note: The charges indicated on the request form should reflect the provider's usual and customary charge for the service requested. Providers are reimbursed for authorized services according to the provider *Terms of Reimbursement* issued by the Department of Health and Family Services.

Element 22 — Total Charges

Enter the anticipated total charge for this request.

Element 23 — Signature — Requesting Provider

The original signature of the provider requesting/performing this service must appear in this element.

Element 24 — Date Signed

Enter the month, day, and year the PA/RF was signed (in MM/DD/YY format).

Do not enter any information below the signature of the requesting provider — this space is reserved for Wisconsin Medicaid consultants and analysts.

Appendix 5
Sample Prior Authorization Request Form (PA/RF) for Adult Mental Health Day Treatment Services

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11018 (Rev. 10/03)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code

WISCONSIN MEDICAID
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read your service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

FOR MEDICAID USE — ICN	AT	Prior Authorization Number
		1234567

SECTION I — PROVIDER INFORMATION

1. Name and Address — Billing Provider (Street, City, State, Zip Code)	2. Telephone Number — Billing Provider	3. Processing Type
I.M. Provider **1 W. Wilson** **Anytown, WI 55555**	**(XXX) XXX-XXXX**	**129**
	4. Billing Provider's Medicaid Provider Number **00000026**	

SECTION II — RECIPIENT INFORMATION

5. Recipient Medicaid ID Number	6. Date of Birth — Recipient (MM/DD/YY)	7. Address — Recipient (Street, City, State, Zip Code)
1234567890	**MM/DD/YY**	**609 Willow** **Anytown, WI 55555**
8. Name — Recipient (Last, First, Middle Initial)	9. Sex — Recipient	
Recipient, Im A	☒ M ☐ F	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Primary Code and Description	11. Start Date — SOI	12. First Date of Treatment — SOI
295.32 — paranoid type schizophrenia, chronic state		
13. Diagnosis — Secondary Code and Description	14. Requested Start Date	
301.0 — paranoid personality disorder		

15. Performing Provider Number	16. Procedure Code	17. Modifiers 1	2	3	4	18. POS	19. Description of Service	20. QR	21. Charge
	H2012	**HE**				**11**	**Behavioral health day treatment, per hour**	**10**	**XXX.XX**

An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.

22. **Total Charges** **XXX.XX**

23. **SIGNATURE** — Requesting Provider	24. Date Signed
I.M. Provider	**MM/DD/YY**

FOR MEDICAID USE Procedure(s) Authorized: Quantity Authorized:

☐ Approved _____ Grant Date _____ Expiration Date

☐ Modified — Reason:

☐ Denied — Reason:

☐ Returned — Reason:

_____ **SIGNATURE** — Consultant / Analyst _____ Date Signed

Appendix

Appendix 6
General Medicaid Guidelines for Prior Authorization of Adult Mental Health Day Treatment Services

Use the following information to complete the Prior Authorization/Adult Mental Health Day Treatment Attachment (PA/AMHDTA), HCF 11038:

1. The target population for extended day treatment services are persons with long-term and persistent mental illness or those that have an acute exacerbation of a long-term and persistent mental illness (supported by diagnosis and narrative summary).

2. The following are diagnostic limitations (*Diagnostic and Statistical Manual of Mental Disorders, Third Edition*) for adult mental health day treatment services:

   a. Allowable diagnoses:

      1) Certain psychoses: 295 (Schizophrenic disorders), 296 (Episodic mood disorders, includes episodic affective disorders), and 298 (Other nonorganic psychoses).
      2) Other Disorders: 301 (Personality disorders) and 311 (Depressive disorder, not elsewhere classified).

   b. Possible diagnoses (with careful scrutiny): 300 (Anxiety, dissociative and somatoform disorders), usually limited to 300.11, 300.3, 300.4, 300.81, and 300.9 (the narrative must document interference in life functioning).

   c. All other mental disorder diagnoses as the only (or primary) diagnosis are deemed inappropriate for adult mental health day treatment (i.e., 290-294, 297, 299, 303-305.9, 310) and cannot be covered.

3. The request must include a Mental Health Day Treatment Functional Assessment, HCF 11090, completed within three months prior to the request's date. Requests not meeting this criteria should be returned to the provider. (Refer to HFS 107.13[4][b]2.f., Wis. Admin. Code, for more information).

4. A recipient must have at least a 50 percent likelihood to benefit from day treatment in order to qualify for Medicaid prior authorization (PA), as indicated on the Mental Health Day Treatment Functional Assessment.

5. The recipient must be 18 years of age or older to qualify for adult mental health day treatment services under these guidelines.

6. Those recipients suffering from acute mental illness or a mild mental disorder (i.e., by diagnosis and history they are not suffering from a chronic malady) are generally eligible for hours of treatment preceding the PA threshold. Additional hours may be approved at the consultant's discretion.

7. A recipient with 317 (Mild mental retardation) as the only (or primary) diagnosis is not eligible for adult mental health day treatment services.

8. A recipient whose IQ is 65 or less is not ordinarily eligible for adult mental health day treatment services. The consultant may approve treatment if there is documentation that the recipient would be able to benefit from a treatment program meeting all other requirements for adult mental health day treatment.

9. A recipient who, according to the documentation submitted, is currently abusing alcohol or other drugs is generally not eligible for adult mental heath day treatment services. Adult mental health day treatment may be approved at

the consultant's discretion if evidence of concurrent substance abuse treatment is presented. However, no intensive outpatient substance abuse and adult mental health day treatment may be approved concurrently.

10. A recipient who, by narrative description, is primarily a victim of parental/relationship alcoholism, drug abuse, physical abuse, sexual abuse, or incest, is not generally eligible for generic adult mental health day treatment services. The consultant may approve treatment if there is documentation that the recipient would be able to benefit from a treatment program meeting all other requirements for day treatment.

11. A recipient who, by narrative description, has an identified eating disorder, sexual addiction, or other compulsive/addictive malady is *not* generally eligible for generic adult mental health day treatment services. The consultant may approve treatment if there is documentation that the recipient would be able to benefit from a treatment program meeting all other requirements for adult mental health day treatment.

12. The following categories with hour and time limitations, along with consultant knowledge of the recipient's needs, the provider, and the program offered, are to be used in deciding authorization for the target populations (refer to numbers 1 and 2 listed previously):

    a. *Rehabilitation.* This category is used for all of the target adult mental health day treatment population who may benefit by intensive adult mental health day treatment. Recipients believed to be in this category would receive, at the consultant's discretion, the following:

        1) Threshold hours.
        2) One authorization extension for six months (if requested) of up to 25 hours per week.
        3) Two additional authorization extensions of 10 to 25 hours per week for three months, *only if all of the following occur*:

            - Improvement is shown in the Mental Health Day Treatment Functional Assessment scores (i.e., level of functioning [LOF] and course of functioning [COF]).
            - A plan is developed to transfer the recipient to ongoing community support, vocational rehabilitation, therapeutic living arrangement, etc.
            - There is evidence this process will be completed within one year (e.g., indicated by termination date, previous performance, rehabilitation potential, and narrative history).
            - The narrative indicates that, in the judgment of the provider, rehabilitation potential is "good" or better.

    b. *Maintenance.* This category is for those recipients who, by diagnosis or history, are suffering from a long-term and persistent mental illness or those that have acute exacerbation of a long-term and persistent mental illness as indicated by diagnosis, signs of illness for two or more years, and past intensive adult mental health day treatment has already been tried for six months or more with no apparent change in functional assessment or narrative history. The major goal of adult mental health day treatment here is to maintain the individual in the community and prevent hospitalization. Recipients in this category would receive the following at the consultant's discretion:

        1) Authorization extension for one to six hours per week, for as long as needed (extension length up to 12 months, or the remainder of the calendar year, if requested).
        2) Authorization extension may also be granted for six to 10 hours per week, for three to 12 months (or the balance of the calendar year), depending on the recipient's needs, consultant knowledge of the provider, and the provider's adult mental health day treatment program.

    c. *Stabilization.* This category is for those recipients in the target population who decompensate or have acute exacerbation of a chronic condition. The goal in this category is to "increase structure," stabilize the recipient,

prevent harm to self or others, and prevent hospitalization. Decompensation would be indicated by a recent hospitalization (i.e., within the last 30 days) or other acceptable signs of clear deterioration in LOF and COF. The recipient in this category would receive the following at the consultant's discretion:

1) Initially, an extension of up to 25 hours per week for a single three-month period.
2) Following this, one extension returning to maintenance level (1-10 hours per week), unless rehabilitation potential is clearly demonstrated.

13. Other general considerations for determining adult mental health day treatment hours and eligibility are, at the consultant's discretion, as follows:

a. The LOF score must be between three and 12 for a recipient to be eligible for adult mental health day treatment.

b. The COF score must be between five and 12 for a recipient to be eligible for adult mental health day treatment.

c. If the COF is greater than 12, then the risk of hospitalization needs to be at least 75 percent for a recipient to be eligible for adult mental health day treatment.

d. If the recipient is in a therapeutic or supportive working and living arrangement (i.e., community-based residential facility, sheltered workshop, group home, foster home, or intact family), then fewer hours are indicated for adult mental health day treatment.

e. Discharge from one adult mental health day treatment program to a vocational rehabilitation (sheltered workshop) setting prohibits another intensive mental health day treatment series, unless other criteria are met.

f. A recipient who is involved in primary substance abuse treatment is not generally eligible for adult mental health day treatment services. However, if the recipient has completed primary substance abuse treatment and is in an aftercare service, he or she is eligible for concurrent adult mental health day treatment services at the consultant's discretion. The hours granted would generally fall into the maintenance category.

g. The following activities are *not reimbursed* as adult mental health day treatment hours: meal times, rest periods, transportation, recreation, entertainment, and off-site visits and activities.

Appendix 7
Mental Health Day Treatment Functional Assessment Completion Instructions

(A copy of the Mental Health Day Treatment Functional Assessment Completion Instructions is located on the following pages.)

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WISCONSIN MEDICAID

MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients. Although these instructions refer to Medicaid recipients, all information applies to BadgerCare recipients and SeniorCare participants.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The Mental Health Day Treatment Functional Assessment form, HCF 11090, must be completed each time a functional assessment is performed and kept with the recipient's case records. A mental health day treatment staff member, preferably the recipient's case manager or the primary staff person responsible for the recipient's treatment, is required to complete this form before treatment begins. Providers are required to submit a copy of Section I of this form (which includes demographic and client information) to Wisconsin Medicaid along with the Prior Authorization Request Form (PA/RF), HCF 11018, and the Prior Authorization/Adult Mental Health Day Treatment Attachment (PA/AMHDTA), HCF 11038. Providers should not submit this form with claims for payment.

This is a mandatory form. Wisconsin Medicaid will not accept other versions of this form. Print or type the information on the form so that it is legible.

SECTION I — DEMOGRAPHIC AND CLIENT INFORMATION

Element 1 — Name — Recipient
Print the recipient's last name, first name, and middle initial. Use the Medicaid Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS. Also include the recipient's name at the top of the second and subsequent pages.

Element 2 — Recipient's Medicaid Identification Number
Indicate the recipient's ten-digit Medicaid identification number. Use the recipient's Medicaid identification card or the EVS to obtain the correct identification number.

Element 3 — Date of Initial Assessment
Indicate the date the initial functional assessment was performed. Also include the date of initial assessment at the top of the second and subsequent pages.

Element 4 — Date of Reassessment
Indicate the date the functional reassessment was performed, if applicable. Also include the date of reassessment at the top of the second and subsequent pages.

Element 5
Complete the statement by indicating the total number of hours of day treatment the recipient has received since the initial assessment.

Element 6 — Referral Source
Check the appropriate type of referral.

Element 7 — Name / Agency — Referral Source
Indicate the name of the person or agency making the referral.

Element 8 — Address — Referral Source
Indicate the address, including the street, city, state, and zip code, of the person or agency making the referral.

Element 9
Indicate whether or not the client is presently an inpatient in an acute care general hospital or a psychiatric hospital or is a resident of a nursing home.

Element 10 — Name / Address — Facility
If the answer is "yes" to either question in Element 9, indicate the name and/or address, including the street, city, state, and zip code, of the facility.

Element 11
If the answer is "yes" to either question in Element 9, indicate the date the recipient became an inpatient or resident of the facility. Also indicate the anticipated discharge date (obtained from the facility).

Element 12 — Usual Living Arrangement
Check the appropriate box corresponding to the recipient's usual living arrangement.

Element 13 — Reason for Referral
State briefly the major reason(s) the person was referred to day treatment.

Element 14 — Eligibility Decision Criteria
The information requested in this element makes up the summary of data obtained through performing the complete functional assessment (Sections II-IV). Based on the information contained in this element, the recipient may or may not be eligible for Medicaid reimbursement of day treatment services.

a. *Substance abuse currently:* Indicate whether or not the recipient currently exhibits dependence on or abuse of alcohol or other drugs.

b. *Mental retardation primary diagnosis:* Indicate whether or not the recipient has a primary diagnosis of mental retardation. Mental retardation is defined as anyone with a diagnosis of 317, 318, or 319, according to the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM).

c. *ICD-9-CM: Primary diagnosis code/Secondary and other code:* List the primary and secondary diagnoses using ICD-9-CM diagnosis codes.

d. *Scores, level of functioning (LOF):* Indicate the three scores from the functional assessment scale in the following order: 1) Task Orientation Scale, 2) Social Functioning Scale, and 3) Emotional Functioning Scale. Then add the scores for the total LOF score.

e. *Likelihood of Benefit:* Indicate the answer from Section V, Likelihood of Benefit from Mental Health Day Treatment.

f. *Course of Functioning*: Indicate the total score from Section V, Course of Functioning During the Past Year. The total score is the sum of the scores for indicators 1-5.

g. *Risk of Hospitalization:* Indicate the answer from Section V, Risk of Hospitalization.

Element 15 — Current Services Being Received (Medical and Nonmedical)
Indicate any services the recipient is receiving in addition to day treatment. For example, is the recipient receiving psychotherapy or occupational therapy in addition to day treatment from the provider's facility? Does the recipient attend a sheltered workshop? Does the recipient receive social work services from the county? Does the recipient have a guardian or advocate? These are the types of services (both medical and nonmedical) that should be indicated. If this information is not known, check with the referral source or the county/tribal social or human services agency of the recipient's place of residence.

Element 16 — Signature — Assessor
The person performing the functional assessment (e.g., case manager or primary staff person) is required to sign the form.

Element 17 — Discipline
Indicate the discipline of the assessor.

Element 18 — Date Signed
Indicate the date the form was signed by the assessor.

Element 19 — Signature — Day Treatment Program Director
The day treatment program director is required to sign after reviewing the assessment form.

Element 20 — Date Signed
Indicate the date the form was signed by the day treatment program director.

SECTIONS II-IV — LEVEL OF FUNCTIONING ASSESSMENT SCALES

In each of these sections, circle the indicators on the assessment scale that best describe the recipient's level of functioning. To score each scale, choose the number associated with the circled indicators. If the circled indicators are split between two numbers, score the scale using the lowest number in which indicators are circled, plus a decimal amount that indicates the percent of indicators beyond that number. For example, if on the Social Functioning Scale the provider circled indicators 3c, 3d, 4a, and 4b for a recipient, this scale would have a score of 3.5.

At the bottom of each section, indicate the score for that scale. At the bottom of Section IV, enter the total LOF score, which is the sum of the scores for all three scales (Sections II-IV).

SECTION V — SCORING

Likelihood of Benefit from Mental Health Day Treatment
Circle the appropriate level for the likelihood of benefit and enter the percent score in the scoring box to the right of the scale.

Course of Functioning During the Past Year
Circle the appropriate levels on each scale and enter the scores in the boxes to the right of the scales. Add the scores from scales 1-5 and enter the sum in the "Total (1-5)" scoring box.

Risk of Hospitalization
Circle the appropriate level for the risk of hospitalization and enter the percent score in the scoring box to the right of the scale.

Appendix 8
Mental Health Day Treatment Functional Assessment
(for photocopying)

(A copy of the Mental Health Day Treatment Functional Assessment is located on the following pages.)

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WISCONSIN MEDICAID
MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Mental Health Day Treatment Functional Assessment Completion Instructions, HCF 11090A.

SECTION I — DEMOGRAPHIC AND CLIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)

2. Recipient's Medicaid Identification Number

3. Date of Initial Assessment

4. Date of Reassessment

5. Client has received _____ hours of day treatment since the initial assessment.

6. Referral Source
   - ❑ Hospital ❑ Friend ❑ Self ❑ Physician
   - ❑ Family ❑ Agency ❑ Nursing Home ❑ Other _____

7. Name / Agency — Referral Source

8. Address — Referral Source (Street, City, State, Zip Code)

9. Client presently hospitalized? ❑ Yes ❑ No
   Client presently living in nursing home? ❑ Yes ❑ No

10. Name / Address — Facility (Street, City, State, Zip Code)

11. Resident of Facility Since _____
    Discharge Date _____

12. Usual Living Arrangement
    - ❑ Alone.
    - ❑ Household with spouse and other relatives or with other relatives only.
    - ❑ Group quarters, other than a health-related facility.
    - ❑ Household with spouse only.
    - ❑ Household with nonrelatives.
    - ❑ Community-Based Residential Facility (CBRF).
    - ❑ Other (Specify) _____

13. Reason for Referral

14. Eligibility Decision Criteria
    - a. Substance abuse currently ❑ Yes ❑ No
    - b. Mental retardation primary diagnosis ❑ Yes ❑ No
    - c. ICD-9-CM: Primary diagnosis code _____
      Secondary and other code _____
    - d. Scores, level of functioning (LOF) ____ ____ ____
      (Sections II-IV), total _____
    - e. Likelihood of benefit (Section V) _____%
    - f. Course of functioning (Section V) _____
    - g. Risk of hospitalization (Section V) _____%

15. Current Services Being Received (Medical and Nonmedical)

16. **SIGNATURE** — Assessor

17. Discipline

18. Date Signed

19. **SIGNATURE** — Day Treatment Program Director

20. Date Signed

Continued

Name — Recipient	Date of Initial Assessment	Date of Reassessment

SECTION II — LEVEL OF FUNCTIONING TASK ORIENTATION SCALE

Note: You must know firsthand or have it reliably documented that the client has actually done the tasks.

Indicators:
a. Degree of self-application (concentration, follow through, assuming responsibility) and, if necessary, the amount of guidance (instruction in performance) and support (reinforcement, reassurance) needed to maintain functioning.
b. Relationship of level of stress to task functioning and the amount of support needed to engage or re-engage in tasks.

COMMENTS

1. a. Cannot apply self to any task for any period of time. Demonstrates no goal directed behavior. May wander aimlessly. Guidance and support have no effect on task functioning.
   b. Cannot cope with any stress.

2. a. Rarely concentrates. When alone, rarely follows through with tasks. In a highly structured situation with others, very limited task follow-through even with constant guidance and support.
   b. Functioning breaks down with slightest stress. Needs much support to re-engage.

3. a. Concentrates intermittently. When alone, limited follow-through. Some follow-through with continuous support; no guidance necessary.
   b. With low stress, task functioning breaks down. Support needed to re-engage.

4. a. Concentrates fairly consistently. At times able to follow through. Occasionally assumes responsibility for tasks, when requested to do so, if support is provided.
   b. With low stress, task functioning is usually diminished. Support needed to re-engage.

5. a. Follows through frequently and voluntarily assumes responsibility for tasks. Occasionally needs support.
   b. With low stress, functioning will occasionally be impaired. With moderate stress, functioning will almost always be impaired. Usually needs support to re-engage.

6. a. Concentration is consistent and purposeful. Follows through well and often assumes responsibility for tasks, only requiring support when under stress.
   b. With moderate stress, functioning is usually impaired. Can re-engage by self.

7. a. Concentration is almost always consistent and purposeful. Follows through very well and is actively responsible in relation to tasks. Usually follows through even with frustrating tasks. Task mastery is experienced as valuable and satisfying. Very seldom needs support.
   b. With moderate stress, can maintain functioning. With high stress, functioning is impaired but can re-engage by self.

8. a. Excellent concentration and achievement orientation. Very seldom subject to distraction. Follows through even with the most frustrating tasks. Almost never needs support.
   b. With high stress, functioning only slightly impaired. Can re-engage by self.

SCORE THIS PAGE

Continued

Name — Recipient	Date of Initial Assessment	Date of Reassessment

SECTION III — LEVEL OF FUNCTIONING SOCIAL FUNCTIONING SCALE

Note: Social interaction can be in or out of the program. You must know of its occurrence first hand or it must be reliably documented. Social interaction with staff is not to be taken into consideration when rating.

Indicators:
a. Ability to initiate interpersonal contact.
b. Degree of conversational interaction.
c. Degree of comfort in interpersonal situations.
d. Relationship between level of stress and social functioning. Amount of support needed to engage or re-engage.

COMMENTS

1. a. Does not initiate contact. When approached, no response.
   b. Shows no ability to listen or respond in conversation.
   c. Extreme discomfort being with others.
   d. Unable to cope with any stress.

2. a. Very rarely initiates contact. When approached, sometimes responds.
   b. Rarely listens. Responses not appropriate to conversation flow (lack of continuity, coherence).
   c. General discomfort with others most of the time.
   d. With the slightest stress functioning breaks down. Needs support to re-engage.

3. a. Rarely initiates contact. If approached, almost always responds.
   b. Sometimes listens. Responses occasionally appropriate to conversation flow.
   c. Discomfort with others but can tolerate limited supported interaction.
   d. With low stress, functioning almost always breaks down. Needs support to re-engage.

4. a. Sometimes initiates contact. Always responds.
   b. Usually listens. Responses often appropriate with some sharing in the conversation flow.
   c. Some discomfort but with support can tolerate most interactions.
   d. With low stress, functioning at this level usually diminishes. Needs support to re-engage.

5. a. Often initiates contact.
   b. Can listen well. Usually responds in shared way to the conversation flow.
   c. Usually comfortable with others in interactions that are not stressful.
   d. Under low stress, functioning occasionally breaks down. With moderate stress functioning will almost always be impaired. Usually needs support to re-engage.

6. a. In most cases can initiate contact.
   b. Listens very well. Responds in shared way to conversation flow. At times actively shapes conversation.
   c. Usually comfortable in most interactions.
   d. With moderate stress, functioning is occasionally impaired. Can re-engage by self.

7. a. Almost always able to initiate contact as desired.
   b. Listens with empathy. Not only responds, but actively shapes conversation appropriately.
   c. Not only feels comfortable, but experiences interactions as satisfying.
   d. With moderate stress, can maintain functioning. With high stress, functioning diminishes. Can re-engage by self.

8. a. Initiates contacts as desired.
   b. Listens intuitively. Responds and shapes conversations appropriately, as desired.
   c. Not only feels comfortable, but experiences being with others as self-enhancing.
   d. With high stress, involvement may be diminished, but client is not immobilized.

SCORE THIS PAGE

Continued

Name — Recipient	Date of Initial Assessment	Date of Reassessment

SECTION IV — LEVEL OF FUNCTIONING EMOTIONAL FUNCTIONING SCALE

Indicators:
a. Client's ability to be aware of and understand his emotional states.
b. Client's relationship to his emotional states (overwhelmed? sufficiently controlled? a sense of objectivity?).
c. Amount of support needed to function emotionally, with varying levels of stress.

COMMENTS

1. a. Emotional states appear to be either extremely controlled and rigid (flat) or extremely uncontrolled (labile). Cannot objectively acknowledge his emotions.
   b. Appears severely overwhelmed by emotional experience.
   c. Intervention or support has no effect. Emotional states prevent almost all everyday functioning.

2. a. Although may refer to emotional states, reveals no experienced awareness or objective understanding of emotions at the time they occur.
   b. Excessively overwhelmed by emotions.
   c. Even with constant support, becomes overwhelmed with slightest stress. Needs support to regain functioning.

3. a. Indicates beginning awareness of emotional states, but anxious about this awareness.
   b. Emerging objectivity in relation to emotions, though frequently overwhelmed by his emotions.
   c. Even with constant support, in low stress situations, functioning breaks down.

4. a. Usually aware of emotional states. Indicates an acceptance of emotions as a necessary part of life. May begin to take new actions based on awareness of his emotions.
   b. Some objectivity in relation to his emotions but often feels overwhelmed by them.
   c. Even with frequent support, in low stress situations, functioning is diminished. Needs support to regain functioning.

5. a. Indicates that he is almost always aware of his emotions and is developing an understanding of them.
   b. Somewhat uncomfortable and overwhelmed by his emotions, but still objective enough to begin to understand them.
   c. Even with support, emotional functioning is impaired with moderate stress. Needs support to regain functioning.

6. a. Understands his emotions and how they relate to everyday functioning. Begins to feel comfortable with various emotional states.
   b. Behavior indicates sufficient emotional objectivity to function with flexibility.
   c. Emotional functioning somewhat impaired with moderate stress. At times needs some support to regain functioning.

7. a. Not only understands emotions and how they relate to everyday functioning, but experiences this as satisfying, and a part of emotional growth.
   b. In experiencing diverse emotional states, even extremes, person usually maintains a tempering objectivity.
   c. With high stress, functioning will diminish. Occasionally needs support to regain functioning.

8. a. Indicates thorough understanding of his emotional life and experiences emotional growth as part of a lifelong process.
   b. Wide variety of emotions are experienced in a larger context of emotional growth.
   c. With high stress, functioning slightly impaired. No need for support to regain functioning.

SCORE THIS PAGE

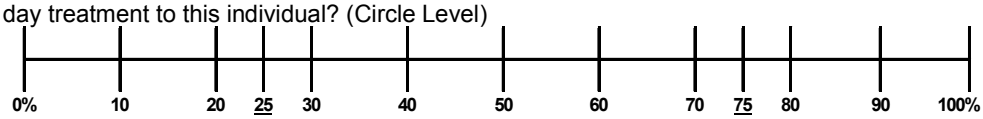
TOTAL LOF SCORE

Continued

Name — Recipient	Date of Initial Assessment	Date of Reassessment

SECTION V — SCORING

Likelihood of Benefit from Mental Health Day Treatment. In comparison with other individuals' day treatment pre-admission functioning and subsequent success in achieving treatment goals, what is the probable benefit of mental health day treatment to this individual? (Circle Level)

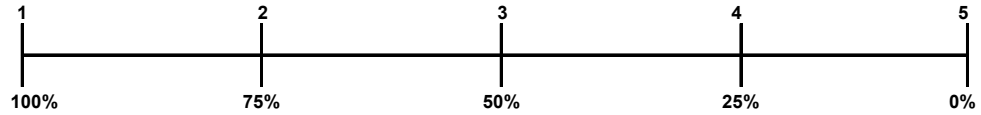


No likelihood of achieving treatment goals — Moderate likelihood in achieving treatment goals — Complete likelihood in achieving treatment goals

Score

Course of Functioning During the Past Year (Circle Level)

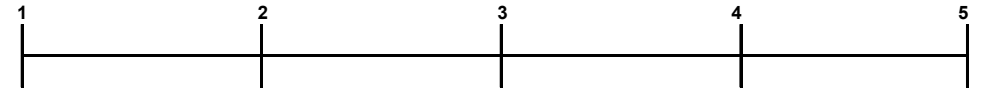
1. *Vulnerability to stress.* What is the likelihood that the individual exhibited severe psychopathological symptoms in response to mild to moderate levels of stress?



Complete likelihood of severe psychopathological symptoms — Moderate likelihood of severe psychopathological symptoms — No likelihood of severe psychopathological symptoms

Score

2. *Activities of daily living skills.* What has been the individual's level of functioning with regard to activities of daily living (e.g., bathing, grooming, and dressing; basic housekeeping and shopping; use of public transportation; preparing or obtaining meals; maintaining prescribed program of medication; taking initiative to seek assistance with problems)?

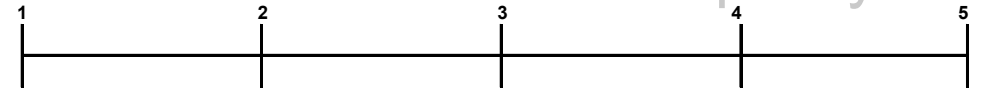


Unable to perform three or more essential activities of daily living without assistance — Unable to perform two essential activities of daily living without assistance — Unable to perform one essential activity of daily living without assistance — Marginal performance of activities of daily living — Adequate performance of activities of daily living

Score

Specify:

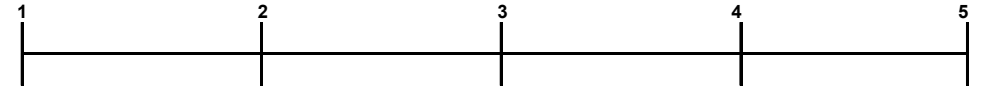
3. *Dependence on institutional and other support systems.* To what extent has the individual required mental hospitalizations or other institutional support or been unable to achieve self-sufficient living?



Has had mental hospital admission — Has been involved in mental health day treatment — Has not required mental health day treatment or more restrictive care

Score

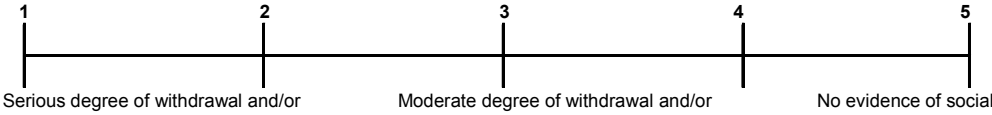
4. *Working in the competitive job market.* To what extreme has the individual been unemployed, sporadically employed, or experienced emotionally related job difficulties?



Extensive periods of unemployment or serious emotionally-related job difficulties — Moderate difficulty in obtaining or maintaining employment or moderate emotionally related job difficulty — No significant difficulty with regard to competitive employment

Score

5. *Interpersonal relations.* To what extent has the individual exhibited social withdrawal and/or inappropriate behavior that interfered with interpersonal relationships necessary for community living?

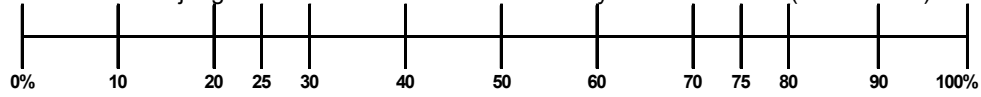


Serious degree of withdrawal and/or inappropriate behavior — Moderate degree of withdrawal and/or inappropriate behavior — No evidence of social withdrawal or inappropriate behavior

Score

TOTAL (1-5)

Risk of Hospitalization. If the individual does not receive mental health day treatment at this time, what is the likelihood of the person requiring inpatient care **within the next three months? Note:** If feasible, this estimate should be made in comparison with other clients with similar diagnoses, levels of functioning, and course of functioning. Also averaging more than one clinical judgment tends to increase the accuracy of this estimate. (Circle Level)



No likelihood of inpatient care — Complete likelihood of requiring inpatient care

Score

Appendix 9
Prior Authorization/Adult Mental Health Day Treatment Attachment (PA/AMHDTA) Completion Instructions

(A copy of the Prior Authorization/Adult Mental Health Day Treatment Attachment [PA/AMHDTA] Completion Instructions is located on the following pages.)

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WISCONSIN MEDICAID
PRIOR AUTHORIZATION / ADULT MENTAL HEALTH DAY TREATMENT ATTACHMENT (PA/AMHDTA) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. Providers should refer to their service-specific handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgment about the case.

Attach the completed Prior Authorization/Adult Mental Health Day Treatment Attachment (PA/AMHDTA), HCF 11038, to the Prior Authorization Request Form (PA/RF), HCF 11018, physician prescription (if necessary), and Section I of the Mental Health Day Treatment Functional Assessment, HCF 11090, and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient
Enter the recipient's name (including last name, first name, and middle initial) exactly as it appears on the recipient's Medicaid identification card.

Element 2 — Age — Recipient
Enter the age of the recipient in numerical form (e.g., 21, 60).

Element 3 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number exactly as it appears on the recipient's Medicaid identification card.

SECTION II — PROVIDER INFORMATION

Element 4 — Name and Credentials — Requesting / Performing Provider
Enter the name and credentials of the therapist who will be providing treatment.

Element 5 — Requesting / Performing Provider's Medicaid Provider No. (not required)

Element 6 — Telephone Number — Requesting / Performing Provider
Enter the performing provider's telephone number, including area code.

Element 7 — Name — Referring / Prescribing Provider
Enter the name of the provider referring/prescribing treatment.

Element 8 — Referring / Prescribing Provider's Medicaid Provider No.
Enter the referring/prescribing provider's eight-digit provider number.

SECTION III — DOCUMENTATION

Per HFS 101.03(37), Wis. Admin. Code, "Adult Mental Health Day Treatment" is described by the following definition:

> "Day treatment" or "day hospital" means a non-residential program in a medically supervised setting that provides case management, medical care, psychotherapy and other therapies, including recreational, physical, occupational and speech therapies, and follow-up services, to alleviate problems related to mental illness or emotional disturbances.

Note: Day treatment services are provided by an interdisciplinary team on a routine, continuous basis for a scheduled portion of a 24-hour day and may include structural rehabilitative activities including training in basic living skills, interpersonal skills and problem-solving skills.

Element 9 — Number of Hours per Week Requested
Enter the number of hours requested per week.

Element 10 — Estimated Final Treatment Date
Enter the estimated final treatment date.

Element 11
Indicate whether or not the recipient has had previous day treatment at the provider's facility or elsewhere.

Element 12 — Evaluation(s)
Describe evaluation(s), including date(s), tests used, and results.

Element 13
Attach Section I of the recipient's most recent functional assessment. (The Mental Health Day Treatment Functional Assessment must be signed and dated within three months of receipt by Wisconsin Medicaid.)

Element 14
Indicate whether or not the recipient's intellectual functioning is below average.

Element 15
Provide a brief history pertinent to requested services. (Include psycho-social history, hospitalization history, family history, living situation history, etc.).

Element 16
Describe progress/status since treatment began or was last authorized, if applicable.

Element 17
Specify overall character of the service to be provided.

Rehabilitation. This category is used for all of the target adult mental health day treatment population who may benefit by **intensive** adult mental health day treatment.

Maintenance. This category is for those recipients who, by diagnosis and history, are suffering from a **chronic mental disorder** as indicated by diagnosis, signs of illness for two or more years, and past intensive adult mental health day treatment that has already been tried for six months or more with no apparent change in functional assessment and/or narrative history. The major goal of treatment here is to **maintain** the individual in the community and prevent hospitalization.

Stabilization. This category is for those recipients in the target population who decompensate and/or have an acute exacerbation of a chronic condition. The goal in this category is to increase structure, stabilize the recipient, prevent harm to self and/or others, and/or prevent hospitalization. Decompensation would be indicated by a recent hospitalization (i.e., within the last 30 days), and/or other acceptable signs of a clear deterioration (in level and course of functioning).

Element 18
Identify measurable treatment goals.

Element 19
Attach a specific schedule of activities, including date, time of day, length of session, and service to be provided.

Element 20
Estimate the recipient's rehabilitation potential for employment (competitive, supported, sheltered, etc.), social interaction, and independent living.

Element 21 — Signature — Recipient or Representative
Enter the signature of the recipient or representative.

Element 22 — Date Signed
Enter the month, day, and year the PA/AMHDTA was signed (in MM/DD/YY format) by the recipient or representative.

Element 23 — Relationship (If Representative)
Include relationship to recipient (if a representative signs).

Element 24 — Signature — Prescribing Physician
Enter the signature of the prescribing physician.

Element 25 — Date Signed
Enter the month, day, and year the PA/AMHDTA was signed (in MM/DD/YY format) by the prescribing physician.

Element 26 — Signature — Therapist Providing Treatment
Enter the signature of the therapist providing treatment.

Element 27 — Date Signed
Enter the month, day, and year the PA/AMHDTA was signed (in MM/DD/YY format) by the therapist providing the treatment.

Element 28 — Signature — 51.42 Board Director / Designee (no longer required)

Element 29 — Date Signed (no longer required)

Appendix 10
Prior Authorization/Adult Mental Health Day Treatment Attachment (PA/AMHDTA) (for photocopying)

(A copy of the Prior Authorization/Adult Mental Health Day Treatment Attachment [PA/AMHDTA] is located on the following pages.)

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WISCONSIN MEDICAID

PRIOR AUTHORIZATION / ADULT MENTAL HEALTH DAY TREATMENT ATTACHMENT (PA/AMHDTA)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616 or by mail to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the PA/AMHDTA Completion Instructions, HCF 11038A.

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)

2. Age — Recipient

3. Recipient Medicaid Identification Number

SECTION II — PROVIDER INFORMATION

4. Name and Credentials — Requesting / Performing Provider

5. Requesting / Performing Provider's Medicaid Provider No.

6. Telephone Number — Requesting / Performing Provider

7. Name — Referring / Prescribing Provider

8. Referring / Prescribing Provider's Medicaid Provider No.

SECTION III — DOCUMENTATION

9. Number of Hours per Week Requested

10. Estimated Final Treatment Date

11. Has the recipient had previous adult mental health day treatment at the provider's facility or elsewhere?

❑ Yes ❑ No ❑ Unknown

If "yes," list dates and locations.

12. Evaluation(s) (Include date[s], tests used, and results.)

Continued

SECTION III — DOCUMENTATION (Continued)

13. Attach Section I of the recipient's most recent Functional Assessment. (The Mental Health Day Treatment Functional Assessment, HCF 11090, must be signed and dated within three months of receipt by Wisconsin Medicaid.)

14. Is the recipient's intellectual functioning below average? ❑ Yes ❑ No
If "yes," what is the recipient's IQ score or intellectual functioning level, and how was this measured?

15. Provide a brief history pertinent to requested services. (Include psycho-social history, hospitalization history, family history, living situation history, etc.)

16. Describe progress / status since treatment began or was last authorized, if applicable.

Continued

SECTION III — DOCUMENTATION (Continued)

17. Specify overall character of service to be provided.

❑ Rehabilitation ❑ Maintenance ❑ Stabilization

18. Identify measurable treatment goals.

19. Attach a specific schedule of activities, including date, time of day, length of session, and service to be provided.

20. Estimate the recipient's rehabilitation potential for employment (competitive, supported, sheltered, etc.), social interaction, and independent living.

Continued

SECTION III — DOCUMENTATION (Continued)

I have read the attached requests for PA of adult mental health day treatment services and agree that it will be sent to Wisconsin Medicaid for review.

21. **SIGNATURE** — Recipient or Representative	22. Date Signed
23. Relationship (If Representative)	
24. **SIGNATURE** — Prescribing Physician	25. Date Signed
26. **SIGNATURE** — Therapist Providing Treatment	27. Date Signed
28. **SIGNATURE** — 51.42 Board Director / Designee	29. Date Signed

Appendix 11
CMS 1500 Claim Form Instructions for Adult Mental Health Day Treatment Services

Use the following claim form completion instructions, *not* the claim form's printed descriptions, to avoid denial or inaccurate Medicaid claim payment. Complete all required elements as appropriate. Do not include attachments unless instructed to do so.

Wisconsin Medicaid recipients receive a Medicaid identification card upon being determined eligible for Wisconsin Medicaid. Always verify a recipient's eligibility before providing nonemergency services by using the Medicaid Eligibility Verification System (EVS) to determine if there are any limitations on covered services and to obtain the correct spelling of the recipient's name. Refer to the Informational Resources section of the All-Provider Handbook or the Medicaid Web site for more information about the EVS.

Submit completed paper claims to the following address:

Wisconsin Medicaid
Claims and Adjustments
6406 Bridge Rd
Madison WI 53784-0002

Element 1 — Program Block/Claim Sort Indicator

Enter claim sort indicator "P" in the Medicaid check box for the service billed.

Element 1a — Insured's I.D. Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the Medicaid identification card or the EVS to obtain the correct identification number.

Element 2 — Patient's Name

Enter the recipient's last name, first name, and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 3 — Patient's Birth Date, Patient's Sex

Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/YYYY format (e.g., February 3, 1955, would be 02/03/1955). Specify whether the recipient is male or female by placing an "X" in the appropriate box.

Element 4 — Insured's Name (not required)

Element 5 — Patient's Address

Enter the complete address of the recipient's place of residence, if known.

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

Element 9 — Other Insured's Name

Commercial health insurance must be billed prior to submitting claims to Wisconsin Medicaid, unless the service does not require commercial health insurance billing as determined by Wisconsin Medicaid.

If the EVS indicates that the recipient has dental ("DEN") or has no commercial health insurance, leave Element 9 blank.

If the EVS indicates that the recipient has Wausau Health Protection Plan ("HPP"), BlueCross & BlueShield ("BLU"), Wisconsin Physicians Service ("WPS"), Medicare Supplement ("SUP"), TriCare ("CHA"), Vision only ("VIS"), a health maintenance organization ("HMO"), or some other ("OTH") commercial health insurance, *and* the service requires other insurance billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three other insurance (OI) explanation codes *must* be indicated in the *first* box of Element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required).

Code	Description
OI-P	PAID by commercial health insurance or commercial HMO. In Element 29 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	YES, the recipient has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to: • The recipient denied coverage or will not cooperate. • The provider knows the service in question is not covered by the carrier. • The recipient's commercial health insurance failed to respond to initial and follow-up claims. • Benefits are not assignable or cannot get assignment. • Benefits are exhausted.

Note: The provider may not use OI-D or OI-Y if the recipient is covered by a commercial HMO and the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not submit claims to Wisconsin Medicaid for services that are included in the capitation payment.

Element 10 — Is Patient's Condition Related to (not required)

Element 11 — Insured's Policy, Group, or FECA Number

Use the *first* box of this element for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Submit claims to Medicare before submitting claims to Wisconsin Medicaid.

Element 11 should be left blank when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- Wisconsin Medicaid indicates the recipient does not have any Medicare coverage including Medicare Cost ("MCC") or Medicare + Choice ("MPC") for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A.
- Wisconsin Medicaid indicates that the provider is not Medicare enrolled.
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits, but do not indicate on the claim form the amount Medicare paid.

If none of the previous statements are true, a Medicare disclaimer code is necessary. The following Medicare disclaimer codes may be used when appropriate.

Code	Description
M-5	**Provider is not Medicare certified.** This code may be used when providers are identified in Wisconsin Medicaid files as being Medicare certified, but are billing for dates of service (DOS) before or after their Medicare certification effective dates. Use M-5 in the following instances: *For Medicare Part A (all three criteria must be met):* • The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A but the provider was not certified for the date the service was provided. • The recipient is eligible for Medicare Part A. • The procedure provided is covered by Medicare Part A. *For Medicare Part B (all three criteria must be met):* • The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B but the provider was not certified for the date the service was provided. • The recipient is eligible for Medicare Part B. • The procedure provided is covered by Medicare Part B.
M-7	**Medicare disallowed or denied payment.** This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use M-7 in the following instances: *For Medicare Part A (all three criteria must be met):* • The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. • The recipient is eligible for Medicare Part A. • The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted. *For Medicare Part B (all three criteria must be met):* • The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. • The recipient is eligible for Medicare Part B. • The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted.
M-8	**Noncovered Medicare service.** This code may be used when Medicare was not billed because the service is not covered in this circumstance. Use M-8 in the following instances: *For Medicare Part A (all three criteria must be met):* • The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. • The recipient is eligible for Medicare Part A. • The service is usually covered by Medicare Part A but not in this circumstance (e.g., recipient's diagnosis). *For Medicare Part B (all three criteria must be met):* • The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. • The recipient is eligible for Medicare Part B. • The service is usually covered by Medicare Part B but not in this circumstance (e.g., recipient's diagnosis).

Elements 12 and 13 — Authorized Person's Signature (not required)

Element 14 — Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 — If Patient Has Had Same or Similar Illness (not required)

Element 16 — Dates Patient Unable to Work in Current Occupation (not required)

Elements 17 and 17a — Name and I.D. Number of Referring Physician or Other Source

Enter the referring physician's name and six-character Universal Provider Identification Number (UPIN). If the UPIN is not available, enter the eight-digit Medicaid provider number or the license number of the referring physician.

Element 18 — Hospitalization Dates Related to Current Services (not required)

Element 19 — Reserved for Local Use (not required)

Element 20 — Outside Lab? (not required)

Element 21 — Diagnosis or Nature of Illness or Injury

Enter the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis. The diagnosis description is not required. Refer to Appendix 2 of this section for a list of diagnosis code restrictions.

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number

Enter the seven-digit prior authorization (PA) number from the approved Prior Authorization Request Form (PA/RF), HCF 11018. Services authorized under multiple PA requests must be billed on separate claim forms with their respective PA numbers. Wisconsin Medicaid will only accept one PA number per claim.

Element 24A — Date(s) of Service

Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one DOS, enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field.
- When billing for two, three, or four DOS on the same detail line, enter the first DOS in MM/DD/YY or MM/DD/YYYY format in the "From" field and enter subsequent DOS in the "To" field by listing *only* the date(s) of the month. For example, for DOS on January 3, 10, 17, and 24, 2006, indicate 01/03/06 or 01/03/2006 in the "From" field and indicate 10/17/24 in the "To" field.

It is allowable to enter up to four DOS per line if the following are true:

- All DOS are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All services have the same place of service (POS) code.
- All services were performed by the same provider.
- The same diagnosis is applicable for each service.
- The charge for all services is identical. (Enter the total charge *per detail line* in Element 24F.)
- The number of services performed on each DOS is identical.
- All services have the same HealthCheck or family planning indicator, if applicable.
- All services have the same emergency indicator, if applicable.

Element 24B — Place of Service

Enter the appropriate two-digit POS code for each service. See Appendix 3 of this section for a list of allowable POS codes.

Element 24C — Type of Service (not required)

Element 24D — Procedures, Services, or Supplies

Enter the single most appropriate five-character procedure code. Wisconsin Medicaid denies claims received without an appropriate procedure code.

Modifiers

Enter the appropriate (up to four per procedure code) modifier(s) in the "Modifier" column of Element 24D.

Note: Wisconsin Medicaid has not adopted all national modifiers.

Element 24E — Diagnosis Code

Enter the number (1, 2, 3, or 4) that corresponds to the appropriate ICD-9-CM diagnosis code listed in Element 21.

Element 24F — $ Charges

Enter the total charge for each line item. Providers are required to bill Wisconsin Medicaid their usual and customary charge. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to Medicaid benefits.

Element 24G — Days or Units

Enter the appropriate number of units for each line item. All day treatment substance abuse services are one-hour procedure codes. When billing for fractions of an hour, indicate units of service in half-hour increments using the standard rules of rounding. Always use a decimal (e.g., 2.0 units).

Minutes Billed	Quantity
1-6	.1
7-12	.2
13-18	.3
19-24	.4
25-30	.5
31-36	.6
37-42	.7
43-48	.8
49-54	.9
55-60	1.0

Element 24H — EPSDT/Family Plan (not required)

Element 24I — EMG

Leave this element blank.

Element 24J — COB (not required)

Element 24K — Reserved for Local Use

When the billing provider (Element 33) is a county/tribal social or human services agency "biller only" provider, enter the eight-digit individual performing provider number of the contracted agency providing the service. Otherwise, leave this element blank. Any other information entered in this element may cause claim denial.

Element 25 — Federal Tax I.D. Number (not required)

Element 26 — Patient's Account No. (not required)

Optional — Providers may enter up to 20 characters of the patient's internal office account number. This number will appear on the Remittance and Status Report and/or the 835 Health Care Claim Payment/Advice transaction.

Element 27 — Accept Assignment (not required)

Element 28 — Total Charge

Enter the total charges for this claim.

Element 29 — Amount Paid

Enter the actual amount paid by commercial health insurance. (If the dollar amount indicated in Element 29 is greater than zero, "OI-P" must be indicated in Element 9.) If the commercial health insurance denied the claim, enter "000." Do *not* enter Medicare-paid amounts in this field.

Element 30 — Balance Due

Enter the balance due as determined by subtracting the amount paid in Element 29 from the amount in Element 28.

Element 31 — Signature of Physician or Supplier

The provider or the authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/YYYY format.

Note: The signature may be a computer-printed or typed name and date or a signature stamp with the date.

Element 32 — Name and Address of Facility Where Services Were Rendered (not required)

Element 33 — Physician's, Supplier's Billing Name, Address, ZIP Code, and Phone

Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number.

Appendix 12
Sample CMS 1500 Claim Form
for Adult Mental Health Day Treatment Services

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ☐ (Medicare #) | MEDICAID ☐ (Medicaid #) | CHAMPUS ☐ (Sponsor's SSN) | CHAMPVA ☐ (VA File #) | GROUP HEALTH PLAN ☐ (SSN or ID) | FECA BLK LUNG ☐ (SSN) | OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY | SEX: M [X] F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown | STATE: WI

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY | STATE

ZIP CODE: 55555 | TELEPHONE (Include Area Code): (XXX)XXX-XXXX

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: M-8

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX: M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX: M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Referring MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 12345678

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 296.5
2. ____.__
3. ____.__
4. ____.__

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 11 07 05		22		H2012	HE U6	1	XX XX	4.0				
2 11 11 05		11		H2012	HE	1	XX XX	6.0				
3 11 14 05	21 28	11		H2012	HE	1	XX XX	8.0				
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $ XX XX

30. BALANCE DUE $ XX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Authorized MMDDYY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555 87654326

PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE*

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500,
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Appendix

Appendix 13
Sample CMS 1500 Claim Form for Adult Mental Health Day Treatment Services, "Biller Only" Providers

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ☐ (Medicare #) | MEDICAID ☐ (Medicaid #) | CHAMPUS ☐ (Sponsor's SSN) | CHAMPVA ☐ (VA File #) | GROUP HEALTH PLAN ☐ (SSN or ID) | FECA BLK LUNG ☐ (SSN) | OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY | SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown | STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] | Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY | STATE

ZIP CODE: 55555 | TELEPHONE (Include Area Code): (XXX)XXX-XXXX

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: M-8

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Referring MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 12345678

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 296.5
2.
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 07 07 05		22		H2012	HE U6	1	XX XX	4.0				76543211
2 07 15 05		11		H2012	HE	1	XX XX	6.0				76543211
3 07 18 05	19 20 21	11		H2012	HE	1	XX XX	10.0				76543211
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE: $ XXX XX

29. AMOUNT PAID: $ XX XX

30. BALANCE DUE: $ XX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Authorized MMDDYY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. County/Tribal Biller-Only
1 W. Williams
Anytown, WI 55555 87654326

PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE*

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500,
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Appendix

Appendix 14
Mental Health and Substance Abuse Services Documentation Requirements

Providers are responsible for meeting Medicaid's medical and financial documentation requirements. Refer to HFS 106.02(9)(a), Wis. Admin. Code, for preparation and maintenance documentation requirements and HFS 106.02(9)(c), Wis. Admin. Code, for financial records documentation requirements.

The following are Wisconsin Medicaid's medical record documentation requirements (HFS 106.02[9][b], Wis. Admin. Code) as they apply to all mental health and substance abuse services. In each element, the applicable administrative code language is in parentheses. The provider is required to include the following written documentation in the recipient's medical record, as applicable:

1. Date, department, or office of the provider, as applicable, and provider name and profession.
2. Presenting problem (chief medical complaint or purpose of the service or services).
3. Assessments (clinical findings, studies ordered, or diagnosis or medical impression):
   a. Intake note signed by the therapist (clinical findings).
   b. Information about past treatment, such as where it occurred, for how long, and by whom (clinical findings).
   c. Mental status exam, including mood and affect, thought processes — principally orientation X3, dangerousness to others and self, and behavioral and motor observations. Other information that may be essential depending on presenting symptoms includes thought processes other than orientation X3, attitude, judgment, memory, speech, thought content, perception, intellectual functioning, and general appearance (clinical findings/diagnosis or medical impression).
   d. Biopsychosocial history, which may include educational or vocational history, developmental history, medical history, significant past events, religious history, substance abuse history, past mental health treatment, criminal and legal history, significant past relationships and prominent influences, behavioral history, financial history, and overall life adjustment (clinical findings).
   e. Psychological, neuropsychological, functional, cognitive, behavioral, and/or developmental testing as indicated (studies ordered).
   f. Current status, including mental status, current living arrangements and social relationships, support system, current activities of daily living, current and recent substance abuse usage, current personal strengths, current vocational and educational status, and current religious attendance (clinical findings).
4. Treatment plans, including treatment goals/objectives, which are expressed in behavioral terms that provide measurable indices of performance, planned intervention, mechanics of intervention (frequency, duration, responsible party[ies]) (disposition, recommendations, and instructions given to the recipient, including any prescriptions and plans of care or treatment provided).
5. Progress notes (therapies or other treatments administered) must provide data relative to accomplishment of the treatment goals in measurable terms. Progress notes also must document significant events that are related to the recipient's treatment plan and assessments and that contribute to an overall understanding of the recipient's ongoing level and quality of functioning.

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